Arizona State University

Name: _____ ASU ID#:_____(*Please Use Blue or Black Ink Only*)

ASU Health Services International Travel Clinic Questionnaire

Today's Date: _____

Your Phone Number: ( ) ____ - _____ **May we leave you voicemail if needed?** Y or N (circle one)

Departure Date: _____/_____/_____ **Return Date**: _____/_____/_____

Your itinerary (please list all countries, cities/towns and ALL excursions planned):

_____

_____

_____

Please thoroughly complete & submit this ASU Travel Questionnaire *at least 4-6 weeks* before your departure date so that you have adequate time to medically prepare for your trip. Please note that in general, it takes at least 2 weeks for most vaccines to become effective.

Depending on availability you may request appointments at any of our clinics (Tempe, Downtown, PolyTech, and West campus). If you need medical clearance for an ASU Study Abroad program and wish to see your own primary care provider, please contact the ASU Study Abroad Office at (480) 965-5965 or studyabroad@asu.edu to request this option. Similarly, if you are a student currently residing in another state and need medical clearance for an ASU Study Abroad Program, please contact the ASU Study Abroad Office for further instructions.

Please make sure to note on the questionnaire any current medical issues and/or if there are any ADDITIONAL non-ASU forms that need to be completed (CIEE, ISA, Semester at Sea, Fulbright, Peace Corps, Missionary or VISA applications, etc) so that we can schedule you with the appropriate medical provider. Otherwise you may be asked to schedule another appointment to address these concerns/forms.

Insurance/Billing: Your medical visits are billed to your insurance (or student account), and you should inquire in advance with your insurance to determine whether they will cover travel services and medications/immunizations.

YELLOW FEVER vaccination is no longer available at ASU Health Services due to a nationwide shortage (if you require this vaccination, we can provide you with information on where you may obtain this vaccination locally).

***FOR ASU STUDY ABROAD STUDENTS: by signing below, you authorize ASU Health Services to share with ASU Study Abroad Office (and those individuals responsible for coordinating your study abroad program) any pertinent but required medical information for your medical clearance (including minimally necessary details on any medications and medical conditions of concern). ASU Health Services does not make decisions about allowing students to participate in ASU Study Abroad Programs- we assess risk and make recommendations to both the student and ASU Study Abroad Office on how to mitigate these risks.

****If you wish to opt out of this and discuss this further at your visit, please initial here*: _____

Signature: _____ **Date:** _____

Please either fax at (480) 907-3040 or bring in your completed travel questionnaire to any ASU Health Services Mon-Fri 8am-5pm. Clinical staff will review your questionnaire prior and determine which appointment(s) will be necessary based on the answers you provided. Feel free to contact ASU Health Services if you have any questions at (480)965-3349.

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ASU Health Services International Travel Questionnaire

To Patients: Please CAREFULLY read and complete this questionnaire. Please submit your questionnaire to ASU Health Services either in-person or fax to **(480) 907-3040** and we'll schedule your appointment accordingly. (NOTE- incomplete or inaccurate responses may lead to delays in scheduling or rescheduling).

	YES	NO
Aside from the ASU Study Abroad department's required medical clearance, do you have a **separate or additional non-ASU** Medical Clearance form that needs to be completed for studying/working/traveling? **Examples: CIEE, ISA, Semester at Sea, Fulbright, Peace Corps, Missionary, or VISA etc- these forms require specific providers signatures, so if applicable please mark "Yes" to avoid scheduling errors**		
Do you have a medical condition that warrants medications or regular physician care (for example: high blood pressure, asthma, diabetes, depression, anxiety, ADHD etc.)?		
Are you 55 years or older?		
Aside from diarrheal/anti-malaria medications and travel vaccinations, will be you requesting ***additional*** prescriptions (including medication refills) at this visit? *Please note that chronic medications generally need to be filled by your primary care provider and not by the travel visit provider.*		
Will the length of your travel be 3 months or greater in Asia, Africa or South America?		

Have you had a fever in the past 48 hours and/or are you feeling sick today?		
Do you have a chronic cough?		
Do you have a new rash or ongoing rash that has not been evaluated?		
Are you pregnant or might you become pregnant on this trip?		
Do you have HIV/AIDS, an AIDS-like condition, any other immune disorder, leukaemia, or cancer?		
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?		
Do you have a low platelet count, a bleeding problem, or blood clotting disorder?		
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or a brain infection?		
Do you have G6PD deficiency?		
Do you have any chronic kidney problems?		
Do you have a chronic gastrointestinal condition such as ulcers, chronic diarrhea or colitis?		
Have you ever had hepatitis or yellow jaundice?		
Do you have any active mental health issues that require counseling or medications?		
Do you have recurrent nightmares or recurrent anxiety?		
Do you have recurrent or active asthma or a history of anaphylaxis (life-threatening allergic reaction)?		
Do you have any heart disease, with or without symptoms?		
Do you have any chronic eye conditions **aside** from corrective lenses (glasses, contacts)?		
Have you received an organ transplant?		
Are you or will you be taking steroids/prednisone, immune suppressants or anti-cancer drugs?		

For ASU Health Scheduling Staff Only: **Please attach the International Travel COVERSHEET and submit forms to Medical Records for scanning.)**

***For Tempe Scheduling Only*: If any "YES" to the above, please schedule the patient with a Travel Medicine Clinician AND Travel Nurse Clinic; if "NO" to all of the above, may schedule patient for Travel Nurse Clinic only.**

***TO PATIENTS*- Please continue to complete the remainder of the questionnaire**

	YES	NO
Have you ever fainted from having your blood drawn or from an injection?		
Have you ever had a fever or adverse reaction to a vaccination?		
Do you live (or work closely) with anyone who has AIDS, any other immune disorder, on immune suppressive therapy or on chemotherapy for cancer?		
Does any person who lives with you or any person you take care of take cortisone, prednisone, other steroids, or receive radiation treatments?		
Please list any current medications you are taking (prescription and over-the-counter):		

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Immunization and Allergy History

******PLEASE BRING A COPY OF YOUR PREVIOUS VACCINATION RECORD TO YOUR VISIT FOR MEDICAL PROVIDER REVIEW AND CONFIRMATION***

Vaccination History (please complete any known dates below)					
MMR (mumps, measles, rubella)	1. 2.	Tetanus (DPT, DTaP, Td, Tdap)	1. 4. 2. 5. 3. 6.	Varicella (Chicken Pox)	1. 2. or Previous Illness ( ) year
Hepatitis A Hepatitis B	1. 2. 1. 2. 3.	Polio	1. 2. 3. 4. 5.	Influenza (flu)	Last date received
Meningitis (*ACWY* or Men*B*, circle type if known)	1. 2. 3.	Typhoid (oral or injectable, circle type if known)	1. 2.	Pneumonia (Pneumovax PPSV23 or Prevnar 13)	1. 2.
Human Papilloma Virus (HPV)	1. 2. 3.	Yellow Fever Cholera	1. 2. 1.	Japanese Encephalitis Rabies	1. 2. 1. 2. 3.
Other vaccinations received not listed above:					
Please list any previous vaccine adverse reactions:					

Are you allergic to any of the following below? (circle those that apply and indicate reaction details below)

Eggs	Yeast	Gelatin	Bee Stings	Latex	Aluminium
Penicillin	Sulfa/Sulfur	Thimerosal	Phenol	Neomycin	Streptomycin
Formalin	Polymyxin B	Amphotericin B	2-phenoxyethanol		
Chlortetracycline	Protamine Sulfate				

Adverse Reaction Detail (if any above circled):

Signature:_____ **Date:** _____

(Patient to please sign PRIOR to submission of questionnaire)